



Facility Name & ID Number Kewanee Care Home# 0026518 Report Period Beginning: 01/01/2001 Ending: 12/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds05/07/2001

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>6</u>	Skilled (SNF)	<u>11</u>	<u>3,385</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>70</u>	Intermediate (ICF)	<u>65</u>	<u>24,355</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,740</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,470</u>	<u>1,470</u>	8
9	SNF/PED					9
10	ICF	<u>15,315</u>	<u>10,331</u>		<u>25,646</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,315</u>	<u>10,331</u>	<u>1,470</u>	<u>27,116</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 97.75%

D. How many bed-hold days during this year were paid by Public Aid?

142 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/76

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date                      NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 11 and days of care provided 1,470Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/2001 Ending: 12/31/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	111,300	14,127	4,301	129,728		129,728	24	129,752		1
2	Food Purchase		110,377		110,377		110,377	(5,895)	104,482		2
3	Housekeeping	59,359	14,025		73,384		73,384		73,384		3
4	Laundry	55,163	11,692		66,855		66,855		66,855		4
5	Heat and Other Utilities			68,341	68,341		68,341	445	68,786		5
6	Maintenance	41,809	42,489	9,343	93,641		93,641	545	94,186		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	267,631	192,710	81,985	542,326		542,326	(4,881)	537,445		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	867,490	54,226	1,200	922,916		922,916		922,916		10
10a	Therapy	94,966	1,989	5,445	102,400		102,400		102,400		10a
11	Activities	30,467	1,267	1,350	33,084		33,084		33,084		11
12	Social Services	53,375	573	1,100	55,048		55,048	5	55,053		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,046,298	58,055	21,095	1,125,448		1,125,448	5	1,125,453		16
	<b>C. General Administration</b>										
17	Administrative	151,747		88,830	240,577		240,577	(88,830)	151,747		17
18	Directors Fees										18
19	Professional Services			17,554	17,554		17,554	3,742	21,296		19
20	Dues, Fees, Subscriptions & Promotions			10,288	10,288		10,288	288	10,576		20
21	Clerical & General Office Expenses	43,030	5,056	16,079	64,165		64,165	10,533	74,698		21
22	Employee Benefits & Payroll Taxes			213,370	213,370		213,370	13,841	227,211		22
23	Inservice Training & Education			4,399	4,399		4,399	49	4,448		23
24	Travel and Seminar			12,350	12,350		12,350	1,450	13,800		24
25	Other Admin. Staff Transportation			6,114	6,114		6,114	1,617	7,731		25
26	Insurance-Prop.Liab.Malpractice			44,274	44,274		44,274	2,006	46,280		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	194,777	5,056	413,258	613,091		613,091	(55,304)	557,787		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,508,706	255,821	516,338	2,280,865		2,280,865	(60,180)	2,220,685		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Kewanee Care Home

#0026518

Report Period Beginning:

01/01/2001

Ending:

12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			78,533	78,533		78,533	3,327	81,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,591	154,591		154,591	(13,765)	140,826			32
33	Real Estate Taxes			9,588	9,588		9,588		9,588			33
34	Rent-Facility & Grounds							2,804	2,804			34
35	Rent-Equipment & Vehicles			156	156		156	1,952	2,108			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			242,868	242,868		242,868	(5,682)	237,186			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,543		22,543		22,543		22,543			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,665	40,665		40,665		40,665			42
43	Other (specify):* <b>Nonallowable costs</b>			51,470	51,470		51,470	(51,470)				43
44	<b>TOTAL Special Cost Centers</b>		22,543	92,135	114,678		114,678	(51,470)	63,208			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,508,706	278,364	851,341	2,638,411		2,638,411	(117,332)	2,521,079			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,890)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,704)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,290)	30		9
10	Interest and Other Investment Income	(14,830)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(483)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(19,588)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,615)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(14,373)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,773)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(41,559)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,559)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (117,332)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Kewanee Care Home**  
**Provider # 00026518**  
**12/31/2001**

**Schedule 5A**

**VI. Adjustment Detail**  
**Line 29. Other**

<u>Non-Allowable Expenses</u>	<u>Amount</u>	<u>Reference</u>
Offset vending income	(3,005)	2
Offset miscellaneous income	(229)	21
Disallow Special Events	(2,578)	43
Disallow PAC dues	(59)	20
Disallow vending expense	(1,852)	43
Disallow Radiology	(3,084)	43
Disallow Laboratory	(3,566)	43
Total	<u>(14,373)</u>	

**See Accountants' Compilation Report**

Kewanee Care Home

ID# 0026518

Report Period Beginning: 01/01/2001

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning:

01/01/2001

Ending:

12/31/01

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	24	0	0	0	0	0	0	0	0	0	24	1
2	Food Purchase	(2,890)	0	0	0	0	0	0	0	0	0	0	(2,890)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	445	0	0	0	0	0	0	0	0	0	445	5
6	Maintenance	0	545	0	0	0	0	0	0	0	0	0	545	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,890)</b>	<b>1,014</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,876)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	5	0	0	0	0	0	0	0	0	0	5	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(88,830)	0	0	0	0	0	0	0	0	0	(88,830)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,742	0	0	0	0	0	0	0	0	0	3,742	19
20	Fees, Subscriptions & Promotions	0	347	0	0	0	0	0	0	0	0	0	347	20
21	Clerical & General Office Expenses	0	10,762	0	0	0	0	0	0	0	0	0	10,762	21
22	Employee Benefits & Payroll Taxes	0	13,841	0	0	0	0	0	0	0	0	0	13,841	22
23	Inservice Training & Education	0	49	0	0	0	0	0	0	0	0	0	49	23
24	Travel and Seminar	0	1,450	0	0	0	0	0	0	0	0	0	1,450	24
25	Other Admin. Staff Transportation	0	1,617	0	0	0	0	0	0	0	0	0	1,617	25
26	Insurance-Prop.Liab.Malpractice	0	2,006	0	0	0	0	0	0	0	0	0	2,006	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>(55,016)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(55,016)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,890)</b>	<b>(53,997)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(56,887)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number    Kewanee Care Home#    0026518

Report Period Beginning:

01/01/2001    Ending:

12/31/01

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(3,290)	0	6,617	0	0	0	0	0	0	0	0	3,327	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,830)	0	1,065	0	0	0	0	0	0	0	0	(13,765)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,804	0	0	0	0	0	0	0	0	2,804	34
35	Rent-Equipment & Vehicles	0	0	1,952	0	0	0	0	0	0	0	0	1,952	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(18,120)</b>	<b>0</b>	<b>12,438</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,682)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(40,390)	0	0	0	0	0	0	0	0	0	0	(40,390)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(40,390)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,390)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(61,400)</b>	<b>(53,997)</b>	<b>12,438</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(102,959)</b>	<b>45</b>

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/2001 Ending: 12/31/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	100%	See Attached Schedule		See Attached Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care Companies	100.00%	\$ 24	\$ 24 1
2	V	5 Utilities		Petersen Health Care Companies	100.00%	445	445 2
3	V	6 Maintenance Supplies		Petersen Health Care Companies	100.00%	545	545 3
4	V	12 Social Services		Petersen Health Care Companies	100.00%	5	5 4
5	V	17 Administrative	88,830	Petersen Health Care Companies	100.00%		(88,830) 5
6	V	19 Professional Services		Petersen Health Care Companies	100.00%	3,742	3,742 6
7	V	20 Fees, Subscriptions, & Dues		Petersen Health Care Companies	100.00%	347	347 7
8	V	21 Clerical & General Office Exp.		Petersen Health Care Companies	100.00%	10,762	10,762 8
9	V	22 Employee Benefits		Petersen Health Care Companies	100.00%	13,841	13,841 9
10	V	23 Inservice Training & Education		Petersen Health Care Companies	100.00%	49	49 10
11	V	24 Travel & Seminar		Petersen Health Care Companies	100.00%	1,450	1,450 11
12	V	25 Other Admin. Staff Transport		Petersen Health Care Companies	100.00%	1,617	1,617 12
13	V	26 Insurance		Petersen Health Care Companies	100.00%	2,006	2,006 13
14	Total		\$ 88,830			\$ 34,833	\$ * (53,997) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      **Kewanee Care Home**#      **0026518**Report Period Beginning:      **01/01/2001**      Ending:      **12/31/01****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**

☒ YES      ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	30 Depreciation Expenses	\$	Petersen Healthcare Companies	100.00%	\$ 6,617	\$ 6,617		15
16	V	32 Interest		Petersen Healthcare Companies	100.00%	1,065	1,065		16
17	V	34 Rent-Facility & Grounds		Petersen Healthcare Companies	100.00%	2,804	2,804		17
18	V	35 Rent-Equipment		Petersen Healthcare Companies	100.00%	1,952	1,952		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 12,438	\$ *	12,438	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

**Kewanee Care Home**  
**Provider # 00026518**  
**12/31/2001**

**VII Related Parties-Page 6**

**Related Nursing Home**

**City**

Robings Manor Nursing Home  
Countryview Terrace  
Sunset Manor Nursing Home  
Kewanee Care Home  
Arcola Health Care Center  
Eastview Terrace  
Havana Health Care Center  
Prairie City Health Care Center

Brighton, IL  
Louisville, IL  
Canton, IL  
Kewanee, IL  
Arcola, IL  
Sullivan, IL  
Havana, IL  
Prairie City, IL

**Out of State Nursing Home**

Friendly Village  
Horizons Unlimited  
Taylor Park  
Passport  
Meadow Lawn Nursing Center  
Cumberland Heights-Tomahawk  
Maple Park  
Opportunities Unlimited (Workshop setup, no beds)

Rhineland, WI  
Rhineland, WI  
Rhineland, WI  
Rhineland, WI  
Davenport, IA  
Tomahawk, WI  
Rhineland, WI

**Other Related Business Entities**  
**Petersen Health Care Companies**  
**Petersen Property**

Peoria, IL Management/ Bookkeeping  
Canton, IL Building-Sunset Manor

See Accountants' Compilation Report

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/2001 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Petersen	President	Administrative	100.00	497,306	6	15.00	Salary	\$ 68,695	L17, C1	1
2	Mark Petersen	Secretary	Administrative	0.00	215,749	6	15.00	Salary	29,802	L17, C1	2
3	Todd Petersen	Administrative	Administrative	0.00	62,677	6	15.00	Salary	8,658	L21, C1	3
4											4
5											5
6											6
7					See attached schedule 7A						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 107,155		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Center  
 Provider # 00026518  
 12/31/2001

Schedule 7A

VII. Related Parties (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

Compensation Received From Other Nursing Homes

Name	Bement Health Care	Country View Terrace	Eastview Terrace	Arcola Health Care	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Havana Care Center	Prairie City	Total	Kewanee Care Center	Grand Total
James Petersen	53,064	14,795	52,568	88,261	58,818	60,034	91,851	59,421	18,494	497,306	68,695	566,001
Mark Petersen	23,021	6,419	22,806	38,291	25,517	26,045	39,848	25,779	8,023	215,749	29,802	245,551
Todd Petersen	6,688	1,865	6,625	11,124	7,413	7,566	11,576	7,489	2,331	62,677	8,658	71,335
Total Compensation Received From Other Nursing Homes	82,773	23,079	81,999	137,676	91,748	93,645	143,275	92,689	28,848	775,732	107,155	882,887

See Accountants' Compilation Report

Facility Name & ID Number Kewanee Care Home# 0026518 Report Period Beginning: 01/01/2001 Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care Companies  
 Street Address 7218 North Villa Lake  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309 ) 691-8113  
 Fax Number ( 309 ) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	223,416	8	\$ 200	\$ 27,116	\$ 24	1
2	5	Utilities	Patient Days	223,416	8	3,666	27,116	445	2
3	6	Maintenance	Patient Days	223,416	8	4,490	27,116	545	3
4	10	Nursing	Patient Days	223,416	8	40	27,116	5	4
5	19	Professional Services	Patient Days	223,416	8	30,834	27,116	3,742	5
6	20	Fees, Subscriptions & Dues	Patient Days	223,416	8	2,859	27,116	347	6
7	21	Clerical & General Office Exp.	Patient Days	223,416	8	88,667	27,116	10,762	7
8	22	Employee Benefits	Patient Days	223,416	8	114,040	27,116	13,841	8
9	23	Inservice Training & Education	Patient Days	223,416	8	402	27,116	49	9
10	24	Travel & Seminar	Patient Days	223,416	8	11,946	27,116	1,450	10
11	25	Other Admin. Staff Transport	Patient Days	223,416	8	13,319	27,116	1,617	11
12	26	Insurance	Patient Days	223,416	8	16,524	27,116	2,006	12
13	30	Depreciation	Patient Days	223,416	8	54,520	27,116	6,617	13
14	32	Interest	Patient Days	223,416	8	8,774	27,116	1,065	14
15	34	Rent-Facility & Grounds	Patient Days	223,416	8	23,100	27,116	2,804	15
16	35	Rent-Equipment & Vehicles	Patient Days	223,416	8	16,083	27,116	1,952	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 389,464	\$		\$ 47,271	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kewanee Care Home**# **0026518**

Report Period Beginning:

**01/01/2001**

Ending:

**12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2		3	4	5	6		7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Bank		x	Mortgage	\$17,893.00	11/27/00	\$ 1,527,495	\$ 1,399,986	10/28/03	0.0643	\$ 137,667	1
2	First Bank		x	Van	\$650.00	09/01/98	31,868	12,999	09/01/03	0.0825	2,445	2
3												3
4												4
5												5
	Working Capital											
6				Line of Credit - Note is on Corp. Office but interest paid by facility						0.1000	14,479	6
7												7
8												8
9	TOTAL Facility Related				\$18,543.00		\$ 1,559,363	\$ 1,412,985			\$ 154,591	9
	B. Non-Facility Related*											
10								Home Office Allocation			1,065	10
11								Interest Income Offset			(14,830)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (13,765)	14
15	TOTALS (line 9+line14)						\$ 1,559,363	\$ 1,412,985			\$ 140,826	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT



## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0026518

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE ( 309 ) 691-8113 FAX #: ( 309 ) 691-8622

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>25-04-151-007-0060</u>	<u>144 Junior Ave</u>	\$ <u>8,959.00</u>	\$ <u>8,958.00</u>
2. <u>25-04-152-001-0040</u>	<u>821 Dewey Ave</u>	\$ <u>321.00</u>	\$ <u>321.00</u>
3. <u>25-05-278-007-0030</u>	<u>907 Dewey Ave</u>	\$ <u>45.00</u>	\$ <u>45.00</u>
4. <u>25-05-281-017-0300</u>	<u>901 W. Mill St.</u>	\$ <u>87.00</u>	\$ <u>87.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>9,412.00</u>	\$ <u>9,411.00</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? \_\_\_\_\_ YES    x \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 12,548

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	42,000	1976	\$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		\$ 50,621	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning:

01/01/2001

Ending:

12/31/01

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65	1976		\$ 381,128	\$ 1,474	30	\$ 12,704	\$ 11,230	\$ 332,699
5	6	1998		753,696	19,325	40	18,842	(483)	67,517
6									
7									
8									
Improvement Type**									
9	Various	1984		14,365	718	30	479	(239)	8,177
10	Various	1985		7,400	385	10		(385)	7,400
11	Various	1987		10,278	326	10-15	492	166	9,869
12	Various	1988		14,958	476	10-15	489	13	14,622
13	Various	1989		1,900	60	15	127	67	1,606
14	Various	1991		8,793	279	15	586	307	6,303
15	Various	1992		16,898	536	12	1,408	872	13,963
16	Various	1993		4,962	207	10	496	289	4,318
17	Various	1994		22,158	568	15	1,477	909	10,463
18	Various	1995		31,243	1,324	20	1,562	238	10,190
19	Tile Flooring	1996		1,083	28	20	54	26	315
20	Curtains Custom	1996		1,275	114	20	64	(50)	363
21	Emergency Light	1996		304	27	20	15	(12)	85
22	Fire Alarm	1996		2,099	187	20	105	(82)	595
23	Tile Flooring	1996		1,287	33	20	64	31	357
24	Boiler	1996		2,995	77	20	150	73	788
25	Water Heater Repair	1996		1,010		20	51	51	302
26	Ceiling Repairs	1996		2,117		20	106	106	627
27	Piping Repairs	1996		855		20	43	43	254
28	Fire Alarm	1996		1,331		20	67	67	346
29	Fire System	1996		1,564		20	78	78	423
30	Landscaping	1996		9,815		20	491	491	2,741
31	Landscaping	1996		1,986		20	99	99	528
32	Chrome Door Knob	1996		72		20	4	4	23
33	Emergency Light	1996		182		20	9	9	54
34	Painting	1996		672		20	34	34	198
35	Floor Tile	1997		8,472	217	20	424	207	2,049
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Storage Shed	1997	\$ 10,177	\$ 261	20	\$ 509	\$ 248	\$ 2,248		37
38	Windows	1997	5,136	132	20	257	125	1,157		38
39	Ceiling Repairs	1997	8,291	213	20	415	202	1,798		39
40	Landscaping	1997	8,085	487	20	404	(83)	1,717		40
41	Landscaping	1997	1,298	78	20	65	(13)	276		41
42	Whirlpool	1997	9,343	240	20	467	227	1,907		42
43	Boiler	1997	3,000	77	20	150	73	625		43
44	Wing Additions	1997	3,700	95	20	185	90	755		44
45	Attic Piping	1997	3,318		20	166	166	733		45
46	Compressor	1997	809		20	40	40	163		46
47	Fire Alarm	1997	2,338		20	117	117	546		47
48	Code Alert Receiver	1997	1,863		20	93	93	434		48
49	New sign	1998	7,304	913	20	730	(183)	2,555		49
50	Landscaping	1998	21,500	1,324	20	1,075	(249)	3,942		50
51	Duct Work-New Wing	1999	1,494	38	20	75	37	187		51
52	Tiling	1999	914	23	20	46	23	115		52
53	Water Heater	1999	2,835	496	20	142	(354)	355		53
54	Water Heater	1999	3,766	659	20	188	(471)	470		54
55	Cubicle Partitions	1999	701	123	20	35	(88)	87		55
56	Beauty Salon	2000	943	24	20	47	23	71		56
57	Tile Flooring	2000	10,294	264	20	515	251	772		57
58	Lot/House Razed	2000	21,237	2,097	20	1,062	(1,035)	1,593		58
59	Concrete	2001	900	45	15	30	(15)	30		59
60	Landscaping	2001	1,045	52	15	35	(17)	35		60
61	Lighting	2001	3,438	26	39	44	18	44		61
62	Blinds/Curtains	2001	9,500		7	679	679	679		62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12B, Carried Forward		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,448,127	\$ 34,028		\$ 48,091	\$ 14,063	\$ 520,469	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete



Facility Name &amp; ID Number      Kewanee Care Home

#      0026518

Report Period Beginning:

01/01/2001

Ending:

12/31/01

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 169,125	\$ 16,732	\$ 16,880	\$ 148	10	\$ 58,876	71
72	Current Year Purchases	27,347	1,775	2,180	405	10	2,180	72
73	Fully Depreciated Assets	105,414				10	105,414	73
74	Allocated from Home Office			6,617	6,617			74
75	TOTALS	\$ 301,886	\$ 18,507	\$ 25,677	\$ 7,170		\$ 166,470	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1997 Dodge Caravan	1998	\$ 32,369	\$ 1,775	\$ 8,092	\$ 6,317	4	\$ 28,322	76
77										77
78										78
79										79
80	TOTALS			\$ 32,369	\$ 1,775	\$ 8,092	\$ 6,317		\$ 28,322	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,833,003	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,310	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,860	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,550	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 715,261	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92	Assisted Living Apartments	\$ 45,969	92
93			93
94			94
95		\$ 45,969	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**1. Name of Party Holding Lease:** N/A

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☐ YES      ☐ NO

**10. Effective dates of current rental agreement:**

## Beginning

Ending

**11. Rent to be paid in future years under the current rental agreement:**

**8. List separately any amortization of lease expense included on page 4, line 34.**

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

**9. Option to Buy:** ☐ **YES** ☐ **NO** **Terms:** \_\_\_\_\_

**15. Is Movable equipment rental included in building rental?**

☐ YES      ☒ NO

16. Rental Amount for movable equipment: \$ 2,108 Description: Copy Machine-\$156; Allocated from Home Office-\$1,952

**(Attach a schedule detailing the breakdown of movable equipment)**

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. **/2002** **\$**

13.                      /2003 \$                     

14.                      /2004 \$                     

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	L10A, C1	2256 hrs	\$ 37,654		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10A, C1 & C2	2160 hrs	57,312			1,989	2,160	59,301		4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39, C2	# of prescripts				22,543		22,543		9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$ 94,966		\$	\$ 24,532	4,416	\$ 119,498		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number      Kewanee Care Home

#      0026518

Report Period Beginning:      01/01/2001

Ending:

12/31/01

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,846,824	\$ 1,846,824	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	600,528	600,528	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,724	12,724	6
7	Other Prepaid Expenses	2,377	2,377	7
8	Accounts Receivable (owners or related parties)	237,695	237,695	8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,700,148	\$ 2,700,148	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,621	50,621	13
14	Buildings, at Historical Cost	1,463,774	1,448,127	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	334,255	334,255	16
17	Accumulated Depreciation (book methods)	(846,727)	(715,261)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Schedule 17A</u>	47,836	47,836	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,049,759	\$ 1,165,578	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,749,907	\$ 3,865,726	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 160,569	\$ 160,569	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,588	58,588	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,412	9,412	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule 17A</u>	19,558	19,558	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 248,127	\$ 248,127	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	12,999	12,999	39
40	Mortgage Payable	1,399,986	1,399,986	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,412,985	\$ 1,412,985	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,661,112	\$ 1,661,112	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,088,795	\$ 2,204,614	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,749,907	\$ 3,865,726	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Kewanee Care Home  
Provider # 00026518  
12/31/2001

**Schedule 17A**

**XV. Balance Sheet - Unrestricted Operating Fund**

**B. Long-Term Assets - Line 23**

	<u>Operating</u>	<u>After Consolidation</u>
Construction in Progress	45,969	45,969
Unamortized Loan Costs	1,867	1,867
Total	<u>47,836</u>	<u>47,836</u>

**XV. Balance Sheet - Unrestricted Operating Fund**

**C. Current Liabilities - Line 36**

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Interest	802	802
Accrued Expense	10,527	10,527
Accrued Sales Tax	483	483
Accrued Insurance	7,746	7,746
Total	<u>19,558</u>	<u>19,558</u>

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,864,344</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustments</b>	<b>(45,346)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,818,998</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>269,797</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 269,797</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 2,088,795</b>	<b>24 *</b>

Operating entity only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning: 01/01/2001

Ending:

12/31/01

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,799,208	1
2	Discounts and Allowances for all Levels	(4,681)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,794,527	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,888	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 90,888	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,890	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,890	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,830	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,830	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	5,073	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,073	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,908,208	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	542,326	31
32	Health Care	1,125,448	32
33	General Administration	613,091	33
<b>B. Capital Expense</b>			
34	Ownership	242,868	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	74,013	35
36	Provider Participation Fee	40,665	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,638,411	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	269,797	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 269,797	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
Entity is a cash basis taxpayer.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



**Kewanee Care Home**  
**Provider # 00026518**  
**12/31/2001**

**Schedule 19A**

**XVII. INCOME STATEMENT**

**Revenue - Line 28**

E. Other Revenue (specify):	Amount
Transportation	439
Vending	3,021
Miscellaneous	1,613
	<u>5,073</u>

**See Accountants' Compilation Report**

Facility Name &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning: 01/01/2001

Ending:

12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 45,000	\$ 21.63	1
2	Assistant Director of Nursing	2,080	2,080	33,600	16.15	2
3	Registered Nurses	1,941	2,101	34,228	16.29	3
4	Licensed Practical Nurses	17,580	17,791	238,842	13.42	4
5	Nurse Aides & Orderlies	52,170	53,843	486,323	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,416	4,416	94,966	21.50	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,538	2,538	24,054	9.48	9
10	Activity Assistants	889	892	6,413	7.19	10
11	Social Service Workers	4,123	4,123	53,375	12.95	11
12	Dietician					12
13	Food Service Supervisor	2,288	2,288	22,844	9.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,583	12,786	88,456	6.92	15
16	Dishwashers					16
17	Maintenance Workers	4,271	4,324	41,809	9.67	17
18	Housekeepers	9,060	9,291	59,359	6.39	18
19	Laundry	8,163	8,376	55,163	6.59	19
20	Administrator	1,907	1,907	53,250	27.92	20
21	Assistant Administrator					21
22	Other Administrative	515	515	98,497	191.26	22
23	Office Manager					23
24	Clerical	3,571	3,605	43,030	11.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Coordinators	2,080	2,080	29,497	14.18	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,255	135,036	\$ 1,508,706 *	\$ 11.17	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	95	\$ 4,168	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	182	5,445	L10A, C3	43
44	Activity Consultant	44	1,350	L11, C3	44
45	Social Service Consultant	44	1,100	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	365	\$ 25,263		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

<b>A. Administrative Salaries</b>				<b>B. Ownership</b>	<b>D. Employee Benefits and Payroll Taxes</b>			<b>F. Dues, Fees, Subscriptions and Promotions</b>	
Name	Function	%	Amount	Description	Amount	Description	Amount		
Greg Wilson	Administrator	0%	\$ 13,000	Workers' Compensation Insurance	\$ 38,584	IDPH License Fee	\$ 400		
Nancy Moranski	Administrator	0%	40,250	Unemployment Compensation Insurance	13,607	Advertising; Employee Recruitment	1,461		
James Petersen	Administrative	100%	68,695	FICA Taxes	102,358	Health Care Worker Background Check (Indicate # of checks performed <u>24</u> )	288		
Mark Petersen	Administrative	0%	29,802	Employee Health Insurance	43,123	Illinois Health Care Association	3,720		
				Employee Meals		Miscellaneous License and Permits	775		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	3,585		
				Employee Relations	11,372	Allocated from Home Office	347		
				401-K	3,621				
				Life Insurance	705				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 151,747	Allocated from Home Office	13,841	Less: Public Relations Expense	( )		
<b>B. Administrative - Other</b>						Non-allowable advertising	( )		
Description			Amount			Yellow page advertising	( )		
Management Fees (Eliminated in column 7)			\$ 88,830						
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 227,211			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,576
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 88,830	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
<b>C. Professional Services</b>				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount				Out-of-State Travel	\$	
Bush & Snyder	Legal	\$	47						
Ginoli & Co.	Accounting		1,040				In-State Travel	10,284	
Altschuler, Melvoin & Glasser	Accounting		7,125						
ADP	Payroll		7,051				Seminar Expense	2,066	
Mid America Programming	Computer Services		1,500				Allocated from Home Office	1,450	
America Online	Computer Services		275	N/A					
AHCA	Computer Services		425				Entertainment Expense	( )	
Bit Wise	Computer Services		55						
Exp@Nets	Computer Services		36						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$	17,554	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$	13,800

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

<b>PROVIDER #</b>	<b>Kewanee Care Center</b>
<b>Period Ending</b>	<b>26518</b>
	<b>12/31/2001</b>

**Schedule 21C**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

Total (agree to Schedule V, line 19, column 3)	17,554
--	--------

Home Office Allocation	Computer Services	1,151	
	Accounting	2345	
	Legal	<u>246</u>	3,742

Total (agree to Schedule V, line 19, column 8)	<u><u>21,296</u></u>
--	----------------------

See Accountants' Compilation Report

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9								N/A					
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kewanee Care Home**

STATE OF ILLINOIS

# **0026518**

Report Period Beginning: **01/01/2001**

Page 23

Ending: **12/31/01**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association-\$3,720
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,461 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,665  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,890
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Total
1. Dietary	111,300	14,127	4,301	129,728	0	129,728	24	129,752
2. Food Purchase	0	110,377	0	110,377	0	110,377	-5,895	104,482
3. Housekeeping	59,359	14,025	0	73,384	0	73,384	0	73,384
4. Laundry	55,163	11,692	0	66,855	0	66,855	0	66,855
5. Heat and Other Utilities	0	0	68,341	68,341	0	68,341	445	68,786
6. Maintenance	41,809	42,489	9,343	93,641	0	93,641	545	94,186
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	267,631	192,710	81,985	542,326	0	542,326	-4,881	537,445
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	867,490	54,226	1,200	922,916	0	922,916	0	922,916
10a. Therapy	94,966	1,989	5,445	102,400	0	102,400	0	102,400
11. Activities	30,467	1,267	1,350	33,084	0	33,084	0	33,084
12. Social Services	53,375	573	1,100	55,048	0	55,048	5	55,053
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,046,298	58,055	21,095	1,125,448	0	1,125,448	5	1,125,453
17. Administrative	151,747	0	88,830	240,577	0	240,577	-88,830	151,747
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	17,554	17,554	0	17,554	3,742	21,296
20. Fees, Subscriptions & Promotion	0	0	10,288	10,288	0	10,288	288	10,576
21. Clerical & General Office	43,030	5,056	16,079	64,165	0	64,165	10,533	74,698
22. Employee Benefits & Payroll	0	0	213,370	213,370	0	213,370	13,841	227,211
23. Inservice Training & Education	0	0	4,399	4,399	0	4,399	49	4,448
24. Travel and Seminar	0	0	12,350	12,350	0	12,350	1,450	13,800
25. Other Admin. Staff Trans	0	0	6,114	6,114	0	6,114	1,617	7,731
26. Insurance-Prop.Liab.Malpractice	0	0	44,274	44,274	0	44,274	2,006	46,280
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	194,777	5,056	413,258	613,091	0	613,091	-55,304	557,787
29. Total General Administrative	1,508,706	255,821	516,338	2,280,865	0	2,280,865	-60,180	2,220,685
30. Depreciation	0	0	78,533	78,533	0	78,533	3,327	81,860
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	154,591	154,591	0	154,591	-13,765	140,826
33. Real Estate	0	0	9,588	9,588	0	9,588	0	9,588
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,804	2,804
35. Rent - Equipment & Vehicles	0	0	156	156	0	156	1,952	2,108
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	242,868	242,868	0	242,868	-5,682	237,186
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	22,543	0	22,543	0	22,543	0	22,543
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	40,665	40,665	0	40,665	0	40,665
43. Other (specify):*	0	0	51,470	51,470	0	51,470	-51,470	0
44. Total Special Cost Ce	0	22,543	92,135	114,678	0	114,678	-51,470	63,208
45. Grand Total	1,508,706	278,364	851,341	2,638,411	0	2,638,411	-117,332	2,521,079

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,846,824	1,846,824
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	600,528	600,528
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	12,724	12,724
7. Other Prepaid Expenses	2,377	2,377
8. Accounts Receivable-Owner/Related Party	237,695	237,695
9. Other (specify):	0	0
10. Total current assets	2,700,148	2,700,148
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	50,621	50,621
14. Buildings, at Historical Cost	1,463,774	1,448,127
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	334,255	334,255
17. Accumulated Depreciation (book methods)	-846,727	-715,261
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	47,836	47,836
24. Total Long-Term Assets	1,049,759	1,165,578
25. Total Assets	3,749,907	3,865,726
CURRENT LIABILITIES		
26. Accounts Payable	160,569	160,569
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	58,588	58,588
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	9,412	9,412
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	19,558	19,558
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	248,127	248,127
LONG TERM LIABILITES		
39. Long-Term Notes Payable	12,999	12,999
40. Mortgage Payable	1,399,986	1,399,986
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	1,412,985	1,412,985
46. Total Liabilities	1,661,112	1,661,112
47. Total Equity	2,088,795	2,204,614
48. Total Liabilities and Equity	3,749,907	3,865,726



	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,799,208
2. Discounts and Allowances for all Levels	-4,681
Subtotal - Inpatient Care	2,794,527
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	90,888
7. Oxygen	0
Subtotal - Ancillary Revenue	90,888
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,890
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	2,890
24. Contributions	0
25. Interest and Other Investments Income	14,830
Subtotal - Non-Operating Revenue	14,830
27. Other Revenue (specify):	5,073
28. Other Revenue (specify):	0
Subtotal - Other Revenue	5,073
30. Total Revenue	2,908,208
31. General Services	542,326
32. Health Care	1,125,448
33. General Administration	613,091
34. Ownership	242,868
35. Special Cost Centers	74,013
35. Provider Participation Fee	40,665
37. Other	0
40. Total Expenses	2,638,411
41. Income Before Income Taxes	269,797
42. Income Taxes	0
43. Net Income or Loss for the Year	269,797

Page

1

2

3

4

5

6

7

8

9

10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

13

14

15

16

17

18

19 The bottom right side of page under \*\*, you must write in any comments

20

21

22

23

## RECONCILIATION REPORT

Kewanee Care Home

03:09 PM 11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-117,332	equal to	-117,332	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	140,826	equal to	140,826	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	9,588	equal to	9,588	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	81,860	equal to	81,860	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,804	equal to	2,804	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,108	equal to	2,108	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	94,966	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	102,400	equal to	102,400	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	24,532	equal to	24,532	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	542,326	equal to	542,326	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,125,448	equal to	1,125,448	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	613,091	equal to	613,091	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	242,868	equal to	242,868	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	74,013	equal to	74,013	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	40,665	equal to	40,665	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing - CPC on Line 33	837,993	equal to	867,490	-29,497	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	94,966	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	30,467	equal to	30,467	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	53,375	equal to	53,375	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	111,300	equal to	111,300	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	41,809	equal to	41,809	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	59,359	equal to	59,359	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	55,163	equal to	55,163	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	151,747	equal to	151,747	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	43,030	equal to	43,030	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,508,706	equal to	1,508,706	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,168	< or = to	4,301	-133	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,200	< or = to	1,200	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,350	< or = to	1,350	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,100	< or = to	1,100	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	151,747	equal to	151,747	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	88,830	equal to	88,830	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	17,554	equal to	17,554	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	227,211	equal to	227,211	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	10,576	equal to	10,576	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	13,800	equal to	13,800	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	40,665	equal to	40,665	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	13,841	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,470	equal to	1,470	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-41,559	equal to	-41,559	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	1,412,985	equal to	1,412,985	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	9,412	equal to	9,412	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,621	equal to	50,621	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,448,127	equal to	1,448,127	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	334,255	equal to	334,255	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	715,261	equal to	715,261	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,088,795	equal to	2,088,795	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	269,797	equal to	269,797	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,749,907	equal to	3,749,907	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1